

FILED AUG 19 1947

State File No.

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 3410

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
In Ambulance on way to Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 yrs (Specify whether years, months or days)
In this community

3. (a) PRINT FULL NAME ALBERT-RAINES-SAUNDERS

3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Male 5. Color or race w 6. (a) Single, widowed, married, divorced Wid

(b) Name of husband or wife Mary Belle Saunders 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr - 4 1869
(Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 3 If less than one day hr. _____ min.

9. Birthplace Shelby Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name Milton Saunders

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Wood

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Robert E Carlisle

(b) Address 33 - W - 74 St

17. (a) Removal (b) Date thereof Aug 9 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Monroe City Mo

18. (a) Signature of funeral director Mr C L Foster

(b) Address 918 Broadway

19. (a) 8-9-47 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 33 - W - 74 St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7 year 1947 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 7 1947 to Aug 7 1947
that I last saw him alive on Aug 7 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction with Decompenstion Duration 3 da

Due to Arteriosclerosis, Cardio-Vascular Disease

Due to

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of operations g3d

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place) (e) Means of injury 0

23. Signature Carl H. Reitz (M. D. or other) M.D.
Address 404 1/2 W. 75th Date signed 8-8-47

2-48 PM
MAR 30 236

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....*Dean Owens*.....

Licensed Embalmer No. *4280*

P. O. Address. *918 Brooklyn*
K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.